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ORIGINAL COMMUNICATIONS.

A FATAL CASE OF CONGENITAL TRACHEO- CESOPHAGEAL FISTULA.

BY D. S. LAMB, M.D.,

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THE patient in this case was seven weeks old at death, March 31, 1873. From its birth almost every attempt at nursing was attended with strangling, and sometimes with lividity of skin. The mother stated that during a portion of the previous summer she had been roughly treated by her husband while he was intoxicated; on several occasions he had violently choked her.

I saw the child for the first time about sixty hours before its death. The most prominent symptom was flatulence, which was abundant, and very painful; there was no vomiting, but there were several thin, greenish stools daily; it nursed but little. The respirations were very hurried, numbering at one time as many as seventy per minute; each respiratory effort was attended with a to-and-fro movement of the head. The cough was slight, infrequent, short, hacking, sometimes provoked by the strangling; occasionally a little froth was brought to the lips, but never thick or dark sputa or blood. The nares were dilated at each inspiration; the mouth was sometimes opened to breathe more easily. He was drowsy much of the time. As a rule, the skin of the trunk and extremities was warm, smooth, and not dry; there was no *pungent* heat; the head at times showed some moisture; the pulse was frequent; the tongue coated thinly whitish.

At the autopsy, a small granular deposit was found upon the mucous membrane of the trachea, just below the fistulous opening; it was suspected to be from a milk-clot, but was washed off and lost before its composition could be made out with certainty. The right lung was very dark and hepatized throughout; there was also slight pleuritic adhesion between the upper and middle lobes; no fluid or lymph in the cavity. The left lung was somewhat emphysematous in the superior lobe; the anterior lower margin to the extent of about a square inch was in the same condition as the right lung; there was neither fluid, lymph, nor adhesion in the left pleura. The heart was normal. Stomach and intestines distended with flatus. Liver, spleen, and kidneys normal. Mesentery somewhat congested.

The head was not examined, except so far as to notice the condition of the palate, which was found normal.

The hyoid bone, larynx, and portions of the trachea and œsophagus were removed. In the median line, nearly half an inch below the lower border of the cricoid cartilage, was a fistulous communication between the two tubes, having a longitudinal diameter of three lines and a transverse diameter of one line; the direction of the fistula

was downwards and backwards, the opening in the œsophagus being at a lower level than that in the trachea; the edges were smooth and rounded, and the mucous membrane normal. The danger of passage of the contents of the œsophagus into the trachea appears to have been guarded against to some extent by the close apposition of the walls of the fistula.

This specimen was contributed to the Army Medical Museum, and is exhibited as Number 1161 of the Medical Section. To show the fistula more distinctly, a whalebone probe was introduced, and the hardening action of the alcohol used as a preservative fluid has rendered the fistulous opening permanently dilated.

I believe this form of defective development of the trachea and œsophagus to be extremely rare. *I have not found any such specimen described either in the museum catalogues or works on pathological anatomy or teratology to which I have had access.*

It does not belong to what have been called "congenital fistulæ of the neck," originally described by Dzondi and Ascherson, since these fistulæ have *external* communications, either asymmetrical (usually in the median line) or symmetrical, close by the internal insertion of the sterno-mastoid muscles; these also have the internal communication with but one tube, either the trachea or œsophagus, never with both in the same case; and sometimes, indeed, the communication with either tube is problematical. Again, these fistulæ have never been recorded as endangering life. (See "The British Record of Obstetric Medicine and Surgery for 1848," published at Manchester, England, and edited by Charles Clay, M.D. Also, "Die Missbildungen des Menschen," by Dr. Förster, Jena, 1865, page 101.)

Probably it should be classed along with those congenital tracheo-œsophageal fistulæ with which are conjoined other malformations of the œsophagus, as, for instance, cul-de-sac termination; but classed as a *variety* in view of the absence of any such complication.

A specimen of "cul-de-sac from a case of imperforate œsophagus, in which the upper portion of the tube terminated on a level with the bifurcation of the trachea, the lower portion of the œsophagus communicated above with the posterior surface of the bifurcation of the trachea," was obtained by me at an autopsy made for Surgeon C. H. Laub, U.S.A., and appears as Number 812, Medical Section, Army Medical Museum. This case was published in the Museum Catalogue, Washington, D.C., 1867. The child lived to be eleven days old; was said to have been able to swallow small quantities of liquid, which produced a gurgling sound in passing through the trachea.

The specimens of congenital deficiency of the neck or its contained viscera, or of the thoracic portions of the trachea or œsophagus, so far as I have found them described in museum catalogues, are very few in number, and all belong to *one* class, viz., *cul-de-sac pharynx or œsophagus*, with or without fistulous communication with the air-passages.

In the Catalogue of the Museum of the Army Medical Department, Fort Pitt, Chatham, London, 1845, page 385, is described as Specimen 2707, "Œsophagus wanting, the pharynx terminating opposite the cricoid cartilage. Taken from an encephalous foetus."

The Catalogue of the Museum of the Royal College of Surgeons of Ireland, Dublin, 1834, Anatomy, volume i. page 152, describes as Specimen G, a. 53, "A case of malformation of the pharynx and trachea in an infant. The pharynx, which is unusually wide, terminates below in a cul-de-sac, without having any connection with the œsophagus. The œsophagus takes origin from the posterior wall of the trachea, by an opening which is so smooth and wide as to render the passage from the larynx into the stomach as direct and easy as that along the trachea into the lungs. See Dublin Hospital Reports, volume v. page 310.—J. H."

The Catalogue of the Royal College of Surgeons of England, London, 1872, Teratological Series, page 91, describes as Specimen 394, "The tongue, pharynx, trachea, and œsophagus of a human foetus, with a small portion of the diaphragm and stomach. The œsophagus opens into the trachea just above its bifurcation; it is not connected with the pharynx. The trachea has been opened in front, and a green-glass rod has been inserted into the œsophagus."

395. "A similar preparation from a new-born child, in which the lungs and stomach are also preserved. The œsophagus is united with the pharynx by a muscular band."

396. "A similar preparation from a human foetus; the lungs are abnormal in form, and have not been inflated with air."

In the Catalogue of the Dupuytren Museum ("Manuel d'Anatomie Pathologique" of Ch. Houel, Paris, 1862, page 778) is described as Specimen 51, "Small child, which lived three days; the œsophagus terminates at its middle part in a cul-de-sac; the lower part communicates with the bronchi."

The Catalogue of the Brolik Museum, Amsterdam, 1865 (Anatomy), page 442, describes as Specimen 311, "Œsophagus and trachea of a child who lived only five days. It could swallow nothing; all it took was rejected, and intermixed with air-bubbles. A little above the origin of the bronchi, the œsophagus terminates in a blind sac; a little lower it is renewed, to open soon into the stomach. The blind sac of the upper part communicates by an oval opening with the trachea. The separation between the œsophagus and the trachea, which is developed from a simple primordial canal, has taken place only imperfectly. Plate xcvi. [xcix. ?], Figures 2 and 3."

The Catalogue of the Boston Society of Medical Improvement, Boston, 1847, page 128, describes as Specimen 456, "Malformation of the œsophagus, from a patient of Dr. Walter Channing. Superiorly, the canal can hardly be said to exist, as it terminates at once in a cul-de-sac behind the larynx; inferiorly, it opens freely into the trachea, just above the bifurcation, but below this it is sufficiently well developed. The child lived five days,

and died, at last, apparently from pneumonia, every attempt to swallow liquids causing great distress, with lividity, and almost suffocation. 1839."

Also, 457, "A second specimen, similar to the last, from a patient of Dr. J. Bigelow. The child was born at the full period, and well developed. On the second day it was observed to take the breast with avidity, but after a few minutes seemed to vomit; liquids also when put into the mouth were immediately rejected; this continued, with much distress and an increasing emaciation, till the eighth day, when it died. Occasionally the respiration was obstructed by a kind of spasm, and there was constantly heard over the chest a mucous, and towards the last a subcrepitan, râle."

"The upper part of the œsophagus is large, quite muscular, and terminates in a cul-de-sac about opposite the middle of the trachea. The lower portion, which is smaller, opens freely into the trachea just above the bifurcation. The stomach was much distended, containing a considerable quantity of brown, viscid fluid, and a large quantity of extremely viscid mucus, which adhered almost everywhere to the inner surface, the membrane itself being softened, as if by the action of gastric juice. The whole of the left lung, except a trace of healthy tissue at the base, and about one-third of the lower lobe of the right lung, was in a state of the most complete apoplexy, looking like a mass of black-currant jelly. The uterus was malformed, and the vagina entirely wanting, though there was nothing unusual in the external organs. It was found, also, that the common trunk of the left subclavian and jugular veins entered the right auricle by a separate opening, instead of uniting with the vena cava. The other organs were well formed."

"It is remarkable that this malformation of the œsophagus, which is, according to M. Andral, quite rare, has been met with in two other cases, at least, in this neighborhood, one of them terminating in eight days, and the other in about twenty-four hours."

The following catalogues contain no specimens of congenital deficiencies of either the trachea or œsophagus:

St. George's Hospital, London, 1866.

St. Bartholomew's, London, 1846 to 1852.

Guy's Hospital, London, 1863.

Army Medical School, Military Surgery, London, 1867.

Royal College of Surgeons, Edinburgh, 1834, Part I.

Thibert Museum, Paris, 1860.

Strasbourg, 1843.

Leipzig, 1819.

Vienna University, Human Anatomy, Vienna, 1869.

Braunschweig, 1854.

Warren Anatomical Museum, Boston, 1870.

New York Hospital, New York, 1860.

Pennsylvania Hospital, Philadelphia, 1869.

I wish to call attention to a similarity in cause of death in several of the cases just described. The two cases from which were obtained Specimens 456 and 457, Bost. Soc. Med. Imp., appear to have ter-

minated fatally from *pneumonia*, as did the case reported by me. In Case 456 there was great distress, with lividity and almost suffocation, on attempting to swallow. In 457 there was also much distress, occasionally a kind of spasm of the respiratory muscles, and mucous râles heard over the chest. At the autopsy the lungs were found in a state described as *currant-jelly* hepatization. This term would very well fit the condition of the lungs in the case reported by me.

It seems quite possible for fluids to find their way into the trachea of an infant, even without any obstruction of the *œsophagus*. In the *Lancet*, London, May 10, 1873, page 669, is an account of the case of a child, aged "one year, which was fed by the bottle, put to bed at six o'clock, and died at midnight with all the signs of intense dyspnoea. At the post-mortem examination (ten hours after death) the two lower lobes of the lungs were found quite softened, grayish, having a smell of butter, and, in a word, having undergone the action of gastric juice. Altered milk was found in the trachea and bronchi. In this case the milk contained in the stomach, and which, doubtless, had been taken in excess, was vomited, and, on account of the horizontal posture, had penetrated into the air-passages.

"Dr. Parrot drew the attention of his colleagues to the importance of the fact from a medico-legal point of view. He thinks that this occurrence must be rather frequent, as he has already witnessed two cases in his own sphere of observation."

Dr. Förster (loc. cit.), describing the *cul-de-sac œsophagus*, states that the malformation "is observed in usually well-formed individuals, that the *œsophagus* in its upper part ends blindly, and thence to the cardia appears only a solid cord; sometimes the upper and lower part of the *œsophagus* exists but the middle is wanting, and is replaced by a solid cord (Plate xxiv., Figure 19). In other cases the *œsophagus* ends in its upper third blindly, and forms with the pharynx a diverticular pouch, but at the same height with the blind end of this pouch, or perhaps a little lower down, the *œsophagus* continues, but opens above into the posterior wall of the trachea (Plate xxiv., Figures 17 to 22). All these defects shut off viability, and the suckling dies the first day after birth [one case above reported lived *eleven* days]. They depend partly upon an arrest of development of the *œsophagus* at the stage of development in which it was yet solid, partly upon an incomplete separation of the trachea from the *œsophagus* with which it originally cohered."

Rokitansky, *Pathological Anatomy*, Vienna, 1861, volume iii. page 128, considers the *cul-de-sac pharynx* conjoined with a communication of the *œsophagus* with the trachea as the result of a destructive process in the foetus.

Andral, *Pathological Anatomy*, Brussels, 1857, volume i. page 474, refers to a case reported by Astley Cooper "in which there was complete absence of the *œsophagus*, the pharynx terminated in *cul-de-sac*, and the stomach was without cardiac orifice; the child lived *eight* days."

In conclusion, I would refer to the following works

for interesting discussions of the subject of *cul-de-sac œsophagus*:

J. H. Hebers, *Pathological Anatomy*, Bonn, 1839, volume ii. pages 142 and 295.

E. Klebs, *Pathological Anatomy*, Berlin, 1868 to 1870, page 164.

Ch. Houel, *Pathological Anatomy*, Paris, 1862, pages 445 and 495.

Thomas Hodgkin, *Morbid Anatomy*, volume ii. Part I., London, 1840, page 247.

M. C. Billard, *Diseases of New-Born Infants*, Paris, 1833, page 494.

Hermann Lebert, *Pathological Anatomy*, Texte II., Paris, 1857 to 1861, page 157.

I have not found either in St.-Hilaire or Serres anything bearing especially upon the subject of this paper.

THE USE OF ATROPIA IN OPIUM-POISONING.

BY DR. H. C. WOOD, JR.,

Clinical Lecturer on Diseases of the Nervous System in the University of Pennsylvania.

THE following case and remarks were sent to me just as given below, by Dr. Robert F. Brooks, of Carthage, Missouri, and seemed to me of such interest that, with his consent, I have sent them to the *Philadelphia Medical Times*. He wished from me an opinion and answers to his inquiries; and perhaps it may not seem egotistical if I give them in print.

In the first place, it is extremely probable that the oak bark, either by its action upon the mucous membrane, or by forming a tannate of the alkaloid, was the cause of the long delay in the production of symptoms by the morphia. In regard to the use of atropia, it seems to me to have been in a great measure judicious.

The point at which to cease the exhibition of the atropia is always a most delicate one to decide; and I can offer no infallible guide. It should not be forgotten that the contraction of the pupil in the advanced stage of opium-poisoning is not due solely to the drug, but also to the accumulation of carbonic acid in the blood from impaired respiration. It is by no means certain that atropia and carbonic acid are antagonistic, even in the sense that atropia and morphia are. Further, the weight of the present evidence seems to me to be in favor of the view that morphia and atropia are not, as regards the pupil, antagonistic. By this I mean that morphia causes contraction by acting on the nerve-centres, atropia, even when injected into the blood, dilatation, by acting locally upon the peripheral nerves of the eye, just as when dropped into the eye. If this be so, it is evident that the state of the pupil does not afford any sure indication as to which drug is influencing most powerfully the nerve-centres.

I do not myself believe the condition of the pupils should be allowed to determine the question as to the further use of the counter-poison, but that the judgment should be made up by surveying the

whole field,—the condition of the respiration, the tendency of the symptoms to become worse or better, the depth of the coma, etc., etc., all being taken into consideration. The cardinal principle *not to give more atropia than is absolutely necessary* should never be lost sight of. Thus, in the present case, as respiration had advanced from naught to ten times a minute, I think it would have been more judicious not to have given the last two injections of atropia, but to have waited to see if the respirations would not rise still more without its further exhibition.

Some experience has shown us that the effect of atropia in these cases, where it once fairly becomes apparent, goes on increasing, so that it may be some hours after the last injection before the mydriatic symptoms are developed in their fullest intensity.

Indeed, in the present case the very noticeable circumstance that the respirations finally rose to double their normal frequency renders it highly probable that the two last injections were unnecessary; and if they were unnecessary they were harmful. If the patient had been a robust man, he very likely would have recovered, as death evidently was due not directly to the poison, but to a secondary exhaustion, coming on after, probably, a large portion of the alkaloid had been eliminated. In conclusion, it is perhaps allowable to call attention to the very striking confirmation which the case affords of my opinion, or belief, that atropia does good in opium-poisoning by acting upon the respiratory centres.

CARTHAGE, MO., June 30, 1873.

On the evening of June 27, 1873, I was called four miles in the country to see Mr. Jackson Gates, a thin tall man, aged 65, nervous, dyspeptic for twenty-five years, whom I found suffering from an attack of cholera morbus. He had cramps of legs, and pain in belly, and was trying to keep from evacuating his bowels, as he fancied the frequent stools (as of soap-suds) made him very weak. He said he had taken nothing but a draught of infusion of oak bark.

I arrived at 9.40 P.M., and during the next hour gave him three doses of sulph. morphia,—in all, between three-quarters of a grain and one grain. I now made up seven papers, each containing $\frac{1}{4}$ gr. morph. sulph. and $\frac{1}{4}$ gr. opium, and gave directions to give one at 11 P.M., and every hour afterwards if his distressing symptoms continued; to stop the medicine if he was at ease or slept.

Returned the next morning at eight o'clock, and found him drowsy, though easily awakened. Pupils not contracted, the conjunctiva red, and excessive itching of the skin. His son, who nursed him, had given the medicine every hour, and had judged it best to give six of the powders, stopping at 5 A.M., or four hours before my second visit. I left him a tonic, and returned home suspecting nothing.

I was recalled just before one o'clock in the afternoon, with the news that my patient could not be awakened, and on arriving, at 1.40, found that he had become quite drowsy at 9 A.M., and could not be waked after 10 A.M., getting worse and worse. His pupils were mere points; his respirations from 2 to 3 per minute, and stertorous; his pulse less than 60; his skin purple; his finger-nails black.

I quickly dashed several pailfuls of cold water, with force, on his bare face, neck, breast, shoulders, and belly, called him loudly, and roused him so that he

begged us to quit. We made him get up and walk, one on each side of him; made him swallow several tablespoonfuls of freshly-ground mustard, a teaspoonful of sulphate of zinc, a tablespoonful of powdered ipecac, and a good deal of warm water. And now, as he refused to walk any more, and commenced to fall down asleep, we again dashed cold water on him, and made him move on. After this he began to be nauseated, and was enough awake to propose to put his finger in his throat so that he might vomit. In this manner we succeeded in getting him to vomit quite freely. At 5 o'clock we began to give him strong coffee, and he got better, yet needed continual nudging and washing of the face with cold water to keep him awake.

Towards 7 o'clock P.M. I obtained the following solution:

R Atropiæ, gr. j,
Acid. acetic., gtt. viij,
Aquæ, ℥j. M. Fiat solutio.

and gave, hypodermically, at 7 P.M., gtt. viij.

His pulse now was 60; at 7.26 pulse 108, and pupils slightly dilated. As the atropia solution dropped from the bottle, one drop proved to be equal to $\frac{3}{16}$ gr., or 8 gtt. = $\frac{1}{4}$ gr.

He now seemed a little better.

Second injection, of gtt. viij, at 9 P.M. Pulse 102, and pupils dilated a little more. Is taking coffee, yet grows worse rapidly.

10.30 P.M.—Douche, walking, shaking, etc., fail, and he can take no more coffee. The atropia acted so feebly that I was discouraged, and did not press it.

At 10.30 P.M. I laid him on a bed and used artificial respiration and jerking for half an hour, when he began to breathe at the rate of eight times a minute.

Third injection, of gtt. x, 12.49 A.M., Sunday, 29th.

3 A.M.—He will not breathe except by jerking, and so continued until afternoon at 3.15 P.M., we all the while staying by him and regularly jerking his body one-fourth circle over at the rate of eight times a minute.

At 3.13 A.M. gave fourth injection of gtt. x.

At 5.45 A.M. pulse 108, and pupils dilated to say twice their natural size.

Fifth injection at 6 A.M., of gtt. x.

I now went home to get a catheter, and happened to think of Dr. H. C. Wood's article in the *American Journal of the Medical Sciences* for April, 1873, as to the use of atropia in cases of opium-poisoning. I eagerly read it, and resolved to press the atropia till I made my patient breathe.

Returned before 9 A.M., and found my patient livid, and that his attendant had been rolling and jerking him assiduously, hardly able to keep his breath in him.

Sixth injection, of gtt. xij, at 8.52 A.M.

Catheterize (enema of whisky ℥ij, milk and egg) at 9.30 A.M.

Seventh injection, of gtt. xij, at 10 A.M.

At 10.30 enema of whisky ℥ss, with milk and an egg. Forced respirations, eight to the minute.

Eighth injection, at 11.8 A.M., gtt. xij. Enema at 11.30 A.M. Am sure by this time that atropia helps his breathing; that is, one need not jerk him so hard to keep him breathing. Pulse of more jerking character.

Ninth injection, at 12 o'clock, of gtt. xij.

Tenth injection, at 1 P.M., of gtt. xij. Enema at 1.30.

Eleventh injection, of gtt. xij. Respirations same. Pulse 108. Enema at 2.40 P.M. Now breathes a little by his own effort, anticipating the monotonous jerking. Pupils do not dilate any more, but stay about twice the natural size.

Twelfth injection, of gtt. xij, at 3 P.M., and at 3.15 P.M. respires voluntarily, at eight times a minute, for the first since 3 A.M. Respirations not stertorous.

He now has twitchings of the muscles, especially of

the shoulders, then of arms, then of chest, and notice when they twitch he at once gasps for breath.

Enema at 3.45 P.M. Pulse 108. Respirations 10.

Thirteenth injection, of gtt. xij, at 4.9. At 5.10 P.M. respirations 12, pulse 108.

At 5.50 P.M. fourteenth and last injection, of gtt. xij. Pulse rises to 120 a minute, and seems weaker. Respirations 12 to the minute.

At 6.30 P.M. use catheter, and then give enema of whisky, etc.

At 7.45 P.M. respirations 16. Enema at 8.30 P.M.

At 10, 12, and 2 o'clock in the night has so much fever that I only give enemata of milk and water. His trembling increases, and before 4 A.M. he coughs and commences to groan, and then to move a little.

At 4 A.M. pulse weaker, 120, and intermits. Give enema of 3ss whisky, etc. He now continually trembles and jerks. All enemata are retained till we use the catheter at 6 A.M., when he evacuates the bowels.

Between 5 and 6 A.M. of 30th begins to swallow: so we give, by the mouth, water, milk, whisky, and broth. He now begins to call out in delirium; opens his hitherto closed and dead-looking eyes; looks wildly here and there; sets the dog after the pigs, and so on. Respirations 36 to the minute; color natural. From this time we endeavor to keep up his strength by stimulants, broth, milk, and enemata of milk, but to no purpose. He grows worse, collapses at 4 P.M., and dies at 5 P.M. Two hours before death his pupils widely dilate.

Remarks.—During Sunday, June 29, while using atropia, face and neck were scarlet color. On weighing specimen of opiate given, I concluded that he could not have taken, from 9.40 P.M., 27th, till 5 A.M., 28th, or seven hours and twenty minutes, more than gr. $1\frac{3}{4}$ of sulph. morphia, and gr. $1\frac{1}{4}$ opium.

The twitchings of muscles and delirium followed the use of the atropia; yet the last atropia was used before 6 P.M. of the 29th, while he did not become delirious until 5 A.M. of the next day. As soon as the injection was given, the skin began to sink to its natural level, and soon afterwards appeared natural.

Did the atropia accumulate and overwhelm the system? How tell when you have given enough? Stillé, vol. i. p. 743, 2d ed., says, "Pupil is an infallible index," etc. Here it was not. My guide was the waking of the respiratory centres: when I was sure he could breathe well, I stopped using the atropia.

Could the infusion of oak bark spoken of have astringed the walls of the stomach to such an extent that the morphia could not be absorbed for several hours, except in very small quantity?

I have calculated that nearly one-half of a grain of atropia was injected.

ROBERT F. BROOKS, M.D.

A CASE OF FRACTURE OF THE SKULL.

Reported by EMORY ESHLEMAN, M.D.

ON the 18th day of July, 1872, Mr. W. S., while following his usual occupation, horse-shoeing, received a violent kick on the head from a horse in proximity to the one upon which he was engaged. Immediately succeeding the occurrence of the accident, two homœopathic practitioners of medicine

and surgery, named respectively Stiles and Middleton, drove to the door, and, of course, had their attention called to the injured man, who was lying bleeding and unconscious on the ground. He in a few moments, however, became so far conscious as to inform those around him of the number of his house. Under the direction of these medical (?) gentlemen, he was immediately placed in a carriage and conveyed to his home, no effort having been made, upon their part, even to arrest the hemorrhage, which, from all accounts, must have been profuse. Arriving at the house of the injured man, these gentlemen immediately made an examination of the condition of affairs, and, after using the probe quite freely, informed his anxious wife, in answer to her interrogatories, that the skull was not fractured, neither, in their estimation, had any serious damage been done to the brain. The injured man, however, said, "My skull is broken, and it is all up with me." He now also, for the first time, became conscious that he was utterly unable to move in the smallest degree any portion of the left half of his body, and asked these gentlemen the cause of this difficulty. He was assured by them that it was a matter of no significance whatever, but resulted from his having lain on that side in his journey from the shop, and that the side was in consequence "asleep or numbed."

After completing the examination, the edges of the wound in the scalp were drawn together and held in apposition by the interrupted suture. Ordering the free application of tincture of arnica to the wounded head, and bottles of warm water to relieve the condition of the left side (paralysis), they took their departure.

Husband and wife, being very much dissatisfied with both the opinions and treatment of these gentlemen, whom most unfortunate circumstances had forced upon them, soon after called upon me.

Upon my arrival I found an incised wound of the scalp, fully four inches in length, occupying the right parietal region, clumsily drawn together by very coarse silk sutures. The man was perfectly conscious, and complained of great pain in the head. There was marked facial paralysis of the left side, and intimated complete hemiplegia of the whole left side of the body.

Having already seen enough of the case to convince me that grave and serious injury had been sustained by both skull and brain, and that there was, in all probability, a depressed fracture of the skull resulting in compression of the brain, I informed the family concerning my apprehensions, and, at the earnest solicitation of the friends, consented to take charge of the case, promising nothing favorable as to the result. Upon introducing the probe through the gap in the scalp, I found the skull depressed as far as the instrument could be carried on either side of the wound. On account of the responsibility of the treatment of this case, my cousin, Dr. J. S. Eshleman, was called in consultation, upon whose arrival the sutures that held the wound together were cut. Immediately beneath the scalp I found several small fragments of brain-substance. Upon introducing that best of all

probes, the finger, abundant proof was afforded of the diagnosis,—a very extensive depressed fracture, confined to the right parietal bone. I could feel distinctly the rough edges of broken bone, and, running the finger along these, could form some idea of the magnitude of the injury. The surface of depressed bone seemed to be about three inches square, and was in three distinct portions. One of these portions, triangular in shape, and occupying a position near the frontal extremity of the bone, seemed to be completely separated from its connection with the surrounding bone. The size of this fragment was one inch in length and three-fourths of an inch in width at its base. In regard to the other two pieces, although depressed in such a manner as in some places to show the whole thickness of the unbroken skull standing above them, the fact of their complete detachment could not be determined. These two pieces were much larger than the one described as triangular.

Having now determined the true condition of affairs, it was decided to relieve the injured brain immediately of the great pressure to which it was subjected; and, the patient being anesthetized, the piece of bone previously spoken of as the triangular one was removed by the ordinary lever belonging to the trephining-case, with some difficulty, although completely detached.

The peculiar manner in which this portion, in common with the others, was driven under and held by the surrounding unbroken skull, rendered its removal very difficult, and made it necessary to enlarge the wound in the scalp one inch. Profuse hemorrhage followed the removal of this portion; and, ice failing to arrest it, bits of lint saturated with Monsel's solution were carefully introduced into the opening, and the bleeding was soon under control. Attention was now directed to the second depressed portion of bone. This was about two inches in length by one inch in width. Its connection with the skull at its occipital end, although not quite severed, was so slight as to make its separation in time a certainty. Owing to its large size, and fearing that the force necessary to effect its detachment from the dura mater and from the skull proper would be followed by a recurrence of exhaustive hemorrhage, it was deemed advisable simply to elevate this larger piece and allow nature to effect its separation. This was with but little effort accomplished.

The third portion, also greatly depressed at its free end, required quite a good measure of force to effect its elevation. The line of fracture extended some distance under the sound scalp in such a manner that its extent could not be determined. It was evident, from the difficulty experienced in its elevation, that its connection must be rather firm, which encouraged the hope that the periosteum remained intact over the greater portion of the line of fracture. The brain was now exposed to view, and could be distinctly seen to rise with every pulsation of its arteries. Both its membranes and substance were somewhat lacerated, as was evinced by the presence of brain-matter outside the broken skull prior to any operative interference. However, close

and satisfactory inspection of the brain and its surroundings was precluded by the blackening produced by the application of Monsel's solution. Our patient by this time began to show symptoms of exhaustion, calling for moderate stimulation. The scalp-wound was gently supported by several adhesive strips. We directed the application of cold water to the head, and on the following morning applied ice-bags, which were kept constantly to the head for three weeks. Morphia was quite freely administered for the relief of pain. Complete hemiplegia persisted until the beginning of the second week, when he was able to move the index-finger, and in a few days more could use the arm sufficiently to fan himself. In about three weeks he could, with but little assistance, walk about his room, and in six weeks walked with ease a half-dozen squares. There was no fungus of the brain.

One week after the occurrence of the accident he had marked erysipelas of the left ear, which, under treatment, subsided without involving the wounded head. There was at no time any very marked evidence of cerebral inflammation, although for several days the temperature was elevated and the pulse accelerated. It may be that the profuse hemorrhage in some measure prevented serious inflammatory action. For some days the bowels refused to act, but under purgatives and full enemata they were freely moved, and remained regular.

The second fragment, whose removal was not at the time considered advisable, remained in the position in which it had been placed. The process of separation was carefully watched, and on the 16th day of September following, about eight weeks after the reception of the injury, was perfectly free so far as bony attachments were concerned, but retaining in a slight measure its connection with the dura mater. Dreading hemorrhage, a silver probe was gently insinuated underneath the bone and the dura mater easily peeled from its under surface, and this large fragment, two inches long and one inch



PIECE OF BONE.

wide, readily removed with the dressing-forceps. No bleeding followed the removal. The sudden removal of so large a portion of the skull gave to the man, as he at the time said, the sensation that he had "lost the roof off his head," and for several days it was impossible to induce him to get off his seat, even to go to bed, for fear his brain would "jump out." His wife informs me that he passed three nights in the chair. In the course of a week he became accustomed to the loss of pressure, and walked about as usual. The wound healed slowly, in consequence of the gradual exfoliation of bone, very small por-

tions coming away weekly. The left side has gradually increased in strength, until now at this date (July 1, 1873) it would be impossible for any one unacquainted with the man's history to perceive any difficulty in walking. The opening in the skull has gradually closed, and is now covered over with a cartilaginous substance. Of course a considerable depression remains at the seat of the removal of bone.

The third portion of bone, which was much larger than either of the others and required so much force to effect its elevation, justified the impression formed at the time, that it was not so nearly separated but that it might remain, by becoming firmly united to the adjoining portion of the skull. There has been no tendency to epilepsy.

This man's skull measured fully three-eighths of an inch in thickness. Mr. S. has for some time been employed in the establishment of Messrs. Powers & Weightman, doing full work.

In conclusion, it seems proper to express the opinion that the good result of the case would not have been achieved without the operative interference which has on various occasions been denounced by the gentlemen of the invisible globules.

TRANSLATIONS.

WERNICH ON AN ADDITIONAL EFFECT OF ERGOT, OF IMPORTANCE TO THE OBSTETRICIAN.

Translated from the *Centralblatt für die Medicin. Wissenschaft.*

BY DR. WM. ASHBRIDGE.

THE results of a large number of experiments, and the frequent mention of a "distended bladder," occurring in the reports of post-mortem examinations, show that the fulness of the bladder found in patients under the influence of ergot is not merely an accidental concomitant of the exhibition of this drug. The explanation of this does not seem far to seek, since the strongly irritant action of the preparations of ergotin upon the sphincter vesicæ is not only a recognized fact, but one that is frequently availed of in therapeutics, in paralysis of the sphincter muscle after typhus, in wetting the bed in children, in the incontinence of the aged, due to simple weakness of the sphincter, in the paralysis of the same muscle in those suffering from paraplegia, etc. But from the circumstance that in animals used for experiments to determine the action of ergotin upon the uterus, in which the bladder, from motives of convenience, had been previously emptied, but yet soon after the administration of the drug was found full of urine, we suspected that in addition to spasm of the sphincter there was still another effect produced by the ergot. This suspicion was strengthened and brought almost to a certainty by the repetition of the same phenomena almost without exception; and, without going into the question whether the increased blood-pressure caused by ergotin is enough to account for the phenomena observed, Wernich feels justified in stating, in opposition to Drasche, that the fulness of the bladder observed after the administration of ergot is due not only to a retention of the normal amount of urine, but also to an increased amount of secretion of that fluid.

Two cases are adduced by Wernich in illustration of his views. The first was a primiparous woman in labor

with twins. After the birth of the first, the bladder emptied itself spontaneously, the os uteri was fully dilated, and the head of the second child presented, but, owing to a cessation of labor-pains, ergot was given at intervals of half an hour during the next three hours. The uterus contracted fully, but the head did not advance. At the return of the doctor the bladder was found very full. It was emptied, and almost immediately the child was born.

The second case was also a primiparous woman, in whom there had been a complete cessation of the pains for some hours; and, as the patient and her friends had a great dread of the forceps, recourse was had to ergot, given in the same dose and at the same intervals as in the previously described case. After the second dose the pains came on, gradually increasing, but by the end of the second hour had not caused the head to advance. The bladder was seen to be greatly distended, and by means of the catheter a large amount of clear urine was drawn off, and at once the head advanced, the forceps were applied, and a male child of normal size extracted.

This is scarcely a matter for the obstetrician, as at all events, before any operative interference, the bladder would be examined; but it is worthy the attention of the assistants of the lying-in woman.

It would be advisable for them to use the catheter after a prolonged ineffectual administration of ergot, as it is quite possible that in many of these cases in which want of power has been attributed to the drug, a contrary verdict would have been rendered had the precaution to relieve a distended bladder been observed.

GRAVE ACCIDENTS CAUSED BY THE APPLICATION OF CHLOR-HYDRATE OF ANILINE IN PSORIASIS.

By DR. LAILLER. Translated from *L'Union Médicale*, No. 67, June, 1873.

BY JEAN PAUL BONISIEUR, M.D.

THE resistance of psoriasis to external remedies is well known. A long list of all kinds have been employed without result. I now have to communicate the grievous results of a series of tentative experiments made by myself.

M. Lutz, the learned pharmacist of the Hospital of St. Louis, proposed the application of a solution of chlor-hydrate of aniline in these inveterate cases. I knew that there had been accidents among the workers in aniline colors, but they had always been attributed to the presence of arsenious acid; nor was I then acquainted with the very interesting articles by M. Beaugrand on poisoning by aniline; but, being assured of its safety by M. Lutz, who had lived for some months in an atmosphere saturated with the vapors of aniline without inconvenience, I did not hesitate to make the essay.

The first application was made on a man æt. 49, very intelligent, who had suffered for thirty-two years with an inveterate psoriasis, which had resisted all treatment both internal and external. He also had pulmonary emphysema, with asthma. The veins of the thoracic walls were largely dilated,—for which we could discover no cause, after a careful examination of the viscera of this region.

April 6.—At half-past six in the evening, a compress containing about 50 grammes of a solution, one-tenth of which was chlor-hydrate of aniline, was applied to the left arm. In an hour and a half after, vomiting occurred, which was repeated from fifteen to twenty times during the night. No diarrhoea; incontinence of urine,

the desire very urgent, slight smarting; very agitated during the night; cold, and icterode.

On the morning, 7th, the color cyanosed, face violet, and the eruption more distinct. Pulse 116, very small, but regular. Some râles in the chest. Pain very severe in the heels and calves. No cramps. Intelligence intact.

On the 8th the normal color is restored, and no trouble remains except pain in the heels. The patient now suffered from an indigestion, beginning after the use of this drug. On the 10th, at the request of the patient, an application of the drug (1 to 20 solvent) was made to the left knee, in order that the absorption might not interfere with respiration. In two hours cephalalgia, deep sleep, chilliness, labored respiration. No nausea, vomiting, nor trouble in micturition. Urine deeply colored, as in the first application. Cyanosis very pronounced. Voice lost.

The following day he had entirely recovered. Thinking these peculiar phenomena might depend on the idiosyncrasy of this individual, or on extreme susceptibility on account of the chest-complication, we made another essay on a patient who had witnessed the preceding experiment and who volunteered himself as a subject.

This patient, a vigorous old man, æt. 68, well preserved and intelligent, had been troubled with an inveterate psoriasis for twenty years, and had been treated by some of the most eminent surgeons of France.

June 6.—The first application of the drug (1 to 500 solvent) was made to the eruption on the right thigh, without appreciable result. The next day an application of 100 grammes of a solution (1 to 50 solvent) was made to the same place. Four hours after, he all at once lost consciousness, and became violet, as if asphyxiated; yet the respiratory movements were free. At the end of a quarter of an hour he recovered himself, though the cyanosis remained for four or five hours, and this gave place to a decided pallor, with abundant cold sweats. Insomnia during the following night. Urine very red. No fever, no vomiting,—differing from the other. Recovered next day.

In the analysis of the foregoing we deduce the following: that, though the structure of the skin is so decidedly altered, yet its power of absorption is little if any impaired, as we see symptoms of grave poisoning in less than two hours; that chlor-hydrate of aniline in medium doses may be a dangerous poison.

It impairs the oxygenation of the blood. The cyanotic appearance simulates that of subjects under the influence of protoxide of azote.

Another analogy between these two agents is the fugacity of the toxic phenomena.

Some essays have been made by Turnbull in the treatment of chorea by the sulphate of aniline, which have been followed by success. But Drs. Fraser and Daves, of London, and M. Bergeron have been less happy with their cases.

ON THE DIAGNOSTIC SIGNS OF FEBRILE DELIRIUM TREMENS.

Translated from *L'Abeille Médicale* of June 9, 1873.

BY JEAN PAUL BONSIEUR, M.D.

M. MAGNAN made a communication before the Société de Biologie on the diagnostic signs of the benign and grave form of inflammatory delirium tremens, and also to anticipate the grave accidents which accompany acute alcoholism.

The most important symptom is rise of temperature. In grave cases it rises from 38° to 39° (Cent.) on the first day, progressively ascending to 40°, 41°, 42°, and, in the height of extreme agony, will rise to 43°; on the

contrary, in the cases terminating in cure, the course of the temperature presents on the first four or five days marked oscillations which show a prompt defervescence; when during the first few days the temperature keeps about 38°, the case is simple and cure certain.

The second sign is the shivering or muscular trembling which pressure on the muscles demonstrates; they are elicited, by percussion or strong pressure, from both the superficial and the deep muscles, and, what is more remarkable, can be produced during the sleep of the patient.

The third sign, less important, is a feebleness and paralysis which often amounts to a paraplegia of the lower extremities. The course of the temperature allows the greatest certainty in the differentiation between delirium tremens from an excess of alcohol, and that of wounded or sick, in whom the temperature is connected with the complications which follow in the course of their affection,—traumatism, pneumonia, erysipelas, etc. In idiopathic inflammatory delirium tremens the course of the temperature is characteristic. The pathological alterations in grave cases are hyperæmia of the gray substance of the cord, with milinary hemorrhages of the same.

The delirium, trembling, agitation, the appearance and heat of the skin, the acceleration of the pulse, afford very little information in this disease; whereas the study of the temperature and of the fibrillous contractions of the muscles affords a great precision both in prognosis and in diagnosis. The above statements are the result of numerous observations made by M. Magnan.

CHANGES IN THE SYMPATHETIC NERVOUS SYSTEM IN CONSTITUTIONAL SYPHILIS.—P. Petrow, of St. Petersburg, describes (*Virchow's Archives*, vol. xvii., March 1, 1873) the changes produced in the sympathetic nerve by syphilis, and arrives at the following conclusions. 1. The general disorder of the organism in syphilis manifests itself plainly in the sympathetic system by changes in the nerve-elements and in the interstitial connective tissue. 2. The nerve-cells undergo (independently of the interstitial changes) pigmented and colloid degeneration,—more frequently the former. 3. The interstitial tissue partakes of the changes undergone by the same structure in other parts of the body, producing atrophy of the nerve-cells and fibres. 4. The endothelium which surrounds the nerve-cells in like manner partakes in the disease. At first there is increased size, with proliferation, of the cells; and afterwards fatty metamorphosis.—*Allgemeine Medicin. Central-Zeitung*, March 12.

A NEW USE FOR OLD STOCKINGS.—A plan of putting up simple fractures of the leg, which is not, we believe, generally known, and which country surgeons may sometimes find convenient, has lately been practised at University College Hospital. The broken limb is first bandaged with an ordinary roller; this is well coated with the gum and chalk mixture; a stocking is slipped on over this and similarly coated; another stocking is put on over this; and a final layer of gum and chalk over all. Thus, for a case of transverse fracture with little displacement, or of fracture of one bone, two or three stockings and a little starch or plaster of Paris supply a very neat and serviceable splint.—*British Medical Journal*, May, 1873.

CUTANEOUS ANÆSTHESIA (*Centralblatt f. d. Med. Wissensch.*, March 22, 1873).—Dr. Horvath, of Kiev, states that while water, ether, and mercury, at a temperature of -5° Centigrade, give intense pain before they produce cutaneous anæsthesia, alcohol and glycerin at the same temperature produce complete anæsthesia without any uncomfortable feelings.

PHILADELPHIA MEDICAL TIMES.

A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

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EDITORIAL.

ECLECTIC STRATEGY.

MISERY makes strange bedfellows, says an old adage; but the wild riding of a hobby sometimes brings a man into even stranger and less desirable company than does misery. The Eden-like innocence and gullibility of men when approached through a violent and quixotic belief is a remarkable feature of human nature. Of all strange illustrations of these truisms the strangest is the sight recently exhibited of the old University of Edinburgh—the castellated home of conservatism, the royal mansion of learning, apparently inaccessible in its pride of an ancient race—sending out to the Far West, through the acts of its leading medical professor, not merely greetings, but words of cheer and encouragement, of praise and endorsement, sending them out not to a new school honestly striving for the spread of true science, but to an institution without repute among the regular profession,—one to bear whose insignia is to become a professional outcast. We do not enter into any discussion with the so-called "eclectics;" what they are and what they believe are as well known to our readers as to us; but certainly their name is, at least in this city, too closely associated with diploma-selling and other vile practices for them to be reckoned even with respectable homœopaths. Here, at least, eclecticism practically shelters men who are unable or unwilling to take an honest place and an honorable position in the regular profession, but resort to all sorts of methods to make money.

It is the sheerest folly for any body of men to claim

to be a medical sect because they do not believe in the use of mercury, antimony, or arsenic. The regular profession enforces no therapeutic accord in its ranks. Any man is at liberty to use or eschew any remedy or set of remedies, according as his fancy dictates.

Professor Bennett is himself a striking proof of this. If it were otherwise, the profession would be broken up into almost as many cliques or divisions as there are drugs in the Pharmacopœia. The cry indulged in by the eclectics against these remedies is simply a battle-cry for plunder,—at least with many of them. It is to attract the multitude, to gain their confidence by agreeing with their prejudices, and thereby to get access to their pockets. In the West, eclecticism may have in its ranks honorable men. If this be so, we call upon them to come out from the others, and we say to them,—Whether you use this drug or that drug, so long as you yourselves allow individual freedom of opinion, so long as you yourselves are tolerant, so long will the regular profession fraternize with you. After all, however, we fear that in the West, as in the East, eclecticism means professional vagabondage; that its followers are the Bedouins, the Ishmaelites, of medicine.

It is into the hands of these gentry that Professor Bennett has fallen. Moved, probably, by letters of congratulation flattering to his pride of discovery and his intensity of belief, he has written the letter which we quote below from an editorial in *The Chicago Medical Times* of July, 1873, where it is headed "J. HUGHES BENNETT STILL IN THE ADVANCE:"

"DEAR SIR,—Your letter reached me here this morning, and I may say at once that I have not the slightest objection to the republication of my report of the Edinburgh Committee's researches on the action of mercury on the liver. I entirely agree with you as to the inutility or injurious character of mercury. As to antimony, I long supposed it served to dissolve the excess of fibrin in the blood, but find I do just as well without it. The influence of arsenic is very doubtful. I *never* give it. Indeed, it may be questioned how any chemical element which forms no part of the animal body can be of the slightest service in curing or relieving its morbid conditions.

"I was especially grieved to learn of the destruction of your college in the great fire of Chicago, but do not doubt that the well-known energy so characteristic of your countrymen will soon replace it on a secure and better footing. I shall be happy, so far as I am able, to contribute to its library a copy of all my works and separate published papers. * * *

"Yours very faithfully,

"J. HUGHES BENNETT.

"VICHY, FRANCE, May 23, 1873."

Because we respect Professor Bennett as an earnest, intelligent, original—although sometimes over-enthusiastic and illogical—student, because we honor the name of the institution which he represents, we are sorry that he has been so entrapped; though we do not wonder at it.

IN the present connection it seems fitting to say a few words about the celebrated researches of Professor Bennett in regard to the action of mercury upon the liver. On behalf of experimental medicine, we want to deny that these researches warrant the deductions which have been drawn from them, and which have not convinced the profession of their truth, but have brought experimental medicine into discredit with clinicians.

In the first place, it must always be borne in mind that there is a limit to be observed in reasoning from experiments.

No experiment is capable of overthrowing a well-known clinical fact. Thus, to quote examples, no experiment on animals could prove that opium is not a soporific, or elaterium a purgative, to man. We hold that every man can for himself on himself prove that calomel will produce an increase of bile in the passages, just as readily as he can that morphia will put him to sleep, and therefore deny that any experiments upon animals can prove the contrary.

In the second place, the effects of disturbing influences upon experimental results must always be borne in mind in reasoning from them. It has been stated by German investigators, and apparently proven, that mercury acts very differently upon dogs with biliary fistulæ than upon uninjured canines. When it is borne in mind that some believe that the calomel is absorbed through the agency of the bile, the significance of this fact is apparent.

Lastly, experiments always need repetition before their results can be accepted as experimental facts. In regard to Professor Bennett's experiments upon mercury, undue haste was, we think, generally shown in accepting them without this repetition, and it now seems most probable that their results were incorrect. Certainly, at the meeting of the *Gesellschaft der Aerzte* of the 28th of March, 1873, a paper was read by Professor Stricker, containing an account of some experiments he had made in conjunction with Dr. Rohrig on the circumstances influencing the secretion of bile, in which he asserted that the old methods of experiment were faulty, and suggested a new plan. He stated that on employing the latter method he had found that *calomel does increase the flow of bile in the dog.*

For these various reasons, we think that it is simply absurd to claim that it has been proved by the researches of Professor Bennett that mercury does not act on the liver.

THE lapse of centuries has not sufficed to surround the names of Cornelius Agrippa and Philippus Paracelsus with the customary halo of antiquity, nor have we yet learned to regard them as other than ignorant and impudent charlatans; but their fumigations, astrological tables, and "sympathetic powders" command a new respect, as at least harmless remedies, when contrasted with some of the blunders made by practitioners of medicine in this era of enlightenment.

An unfortunate lady, twenty-five years of age, being about to be married, and never having menstruated, consulted a physician. After making an examination *per vaginam*, he informed her that she had occlusion of that canal, and proceeded to make an incision through what he called an imperforate hymen. The resulting hemorrhage he declared to be due to the retained catamenia. Painful micturition, dribbling of urine, and finally complete non-retention, followed this operation. After suffering for some time, she applied to another physician for relief. He attributed her difficulty to a condition which he designated as "closure of the urethra," and operated in his turn by dividing the anterior portion of the urethro-vaginal wall. After another long period of pain and misery, she fell into the hands of an educated practitioner, who found that her original condition was due to a congenital absence of the uterus, that the first operation had been through the wall of the bladder, leaving a vesico-vaginal fistula, and that the second had connected this fistula with the orifice of the urethra, laying open that canal along its entire length.

After having life made burdensome for six long years, she is at last on the road to recovery through skilful and judicious surgical treatment.

Our cotemporary who publishes this case, discreetly, and perhaps wisely, gives only the initials of the first two medical attendants; but it seems a shame that such monstrous and inexcusable ignorance cannot be exposed, so that it may at least be avoided.

A FEW weeks since, some laborers near the village of Dervock, County Antrim, Ireland, disinterred from a peat bog the remains of a woman in a curious state of preservation. The integument

was perfect, and was thoroughly tanned, but the bones had lost their solidity and were soft and compressible. The face, ears, tongue, and pharynx were undecomposed, as were the tendons, especially about the joints.

The body occupied a crouching position, about ten feet below the surface, and was five feet and one inch in length.

We have long been familiar with the preservative action of peat, which explains the condition of the soft parts in this case; but the disintegration of the osseous system is not so easily understood. It would seem possible that the presence of iron pyrites or some other oxidizable material might have furnished acid enough to dissolve the mineral constituents of the bones and leave the animal portion almost unaffected, as was found to be the case.

ON June 26 a formal presentation was made to Lady Paget of a beautiful portrait of Sir James Paget, painted in oil by Millais. It had been executed at the request of a large number of pupils, friends, and admirers, and was presented in the great hall of St. Bartholomew's Hospital, by Professor Humphrey, of Cambridge. In receiving the testimonial, Sir James referred with justifiable pride to the fact that there were in the audience three of his old pupils who are at the present time professors in the three most illustrious universities in Great Britain. In behalf of Lady Paget, he begged the governors of the hospital to accept the portrait, which will be hung with those of Abernethy, Earle, Lawrence, and Burrows.

WE are glad to learn that Dr. Sharpey, who has suffered from double cataract for fifteen years, has at last been operated upon successfully, is enjoying tolerably good vision, and has made his appearance again at University College, where it is to be hoped he will resume his valuable labors.

CORRESPONDENCE.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

AS you have incorporated into your editorial upon cholera, of July 19, a lengthy extract from the report made by Dr. F. A. Ramsey to the mayor of Knoxville, relative to the outbreak of that disease in Greeneville, Tennessee, and as the contents of that extract are unreliable and untrue, I hope you will give the writer, who was a resident of Greeneville for twenty-four years previous to 1872, an opportunity to refute the foul as-

persion cast upon the people of his native place, and to show that the cholera data deduced by Dr. Ramsey are more imaginary than real, and offer nothing as to the solution of the problem of the local causes bringing about so terrible an outbreak in a small town. When I read the above-mentioned extract in your editorial, I was perfectly thunder-struck that a man would so outrageously misstate facts and unhesitatingly throw out to the public such a malicious slander upon the good name and decency of the residents of a little village, and that, too, in a nonchalant, facetious way, which seemed to imply that the doctor delighted to ventilate the moral, ethical, and hygienic condition of a scourged people and to bring the reprobation of neighboring towns upon them.

Dr. Ramsey has never been a resident of Greeneville, and I have no knowledge of his having visited the place throughout the past eighteen or twenty years; and where he gathered material to make his report I cannot say. If it had come from Barnum, I would regard it as a huge joke; but emanating from a former editor of a Memphis medical journal, it assumes a more serious aspect.

Says Dr. Ramsey to the astonished mayor of Knoxville, relative to Greeneville, "More than a quarter of a century ago an *immense pit* [*italics my own*] was dug in the very centre of the town, and a cloaca erected over it with a capacity sufficient for the accommodation of the *entire community* during all these years." Strange and infatuated people of Greeneville, that you would all flock to a public privy behind a court-house, twenty feet long and ten feet wide, with only three apartments, making a pilgrimage several times a day to this unhallowed Mecca, according to Dr. Ramsey's statement, instead of enjoying the *privy-acy* of your own backyards! The fact is, Mr. Editor, for many years there has existed a public privy behind the court-house, for the accommodation of *country-people* coming to town to attend to business or to remain during the sitting of the circuit or superior court. The pit of aforesaid privy is about fifteen or twenty feet long, fifteen feet deep, and ten feet wide, and was dug *three years ago,—the old one having been filled up at that time.* This is the *immense* pit that haunted Dr. Ramsey's imagination, and which was for the accommodation of the "whole community." Verily, so overcome (!) am I at this point, the only further comment I can make is, Selah! Some Muse ought to strike the chords of his "heaven-resounding harp," and sing in melodious numbers of this *pit-iful* story, to commemorate a wonderful and lofty flight of the imagination! The energetic citizen of whom Dr. Ramsey speaks as a lineal descendant of Abraham did no more in emptying the contents of this "immense" pit upon his vineyard than many wise men have done and many still do; that art, according to my observation, is practised here in classic New England, where everything is supposed to be done upon scientific principles. Then follow more "vain imaginings:"

"It was the eastern side or slope of the hill on which

the deposit was made; and of course the wash was into and through the town. The heavy wash of this rain carried all the surface-soil from the hill; and, as the water covered an area equal to three-fourths of the corporate extent of the town, the débris from the pit, which it held, fairly divided, if not dissolved, was distributed to just so much of the surface of the ground" (italics my own). This proposition hasn't a living fact to support it, unless water is not subject to the laws of gravitation, and can run up hill as well as down. Water coming from that eastern slope can only run one way after it gets to the bottom of the hill, and that through an open drain on the right side of Depot Street. This drain, as it nears Main Street, runs obliquely east, then southeast into a creek. Therefore, as to this débris being distributed to three-fourths of the corporate extent of the town, which corporate extent is a mile in length by three-quarters in width, there is not a shadow of truth; and the doctor has been misled by somebody as ignorant of the topography of Greenville as he is of the essential element of cholera itself. Why, sir, it would take a flood as big as Noah's was at the end of a fortnight to cover three-fourths of the area of the corporate limits of Greenville, which abounds in hills and valleys throughout its whole extent.

One more flight of the imagination which we wish to follow, and then our criticism is ended. Here comes the "gem,"—a precious stone that never sparkled in any man's intellect during my residence in Greenville, but perhaps during my absence of a year it has sprouted out, and the doctor has discovered it,—i.e., that Greenville people have found out the grape-vine liveth only through copious deposits of human excrement at the "root of each main stem." We quote verbatim et literatim: "But this is not all: the pile is yet incomplete! The town of Greenville is a town of gardens, each garden-owner indulging an emulation as to who would have the best grapes. . . . All the inhabitants of the town believed that the *faecal* deposit made by men, women, and children is of all things the best to give vigor to the grape-vine, fulness to the grape, and luscious delicateness to the flavor and mellowness to the odor of the juice of the fruit. Every cloaca in town," continues the doctor, "surrendered its contents, and at the root of each main stem was buried, in wet earth, a pile of human excrement." Here, again, I'm so astounded at the doctor's flattering compliments to the "men, women, and children" of Greenville, that I'm compelled to pause and reflect upon the frailty of humanity. This proposition I believe to be not only an insult to every "man, woman, and child" in Greenville, but untrue in every particular.

For twenty years previous to 1872 I never knew or heard of any citizen of the town making any such application to his grape-vines; nor do I believe that that custom has been in vogue since 1872. As for the "lusciousness, delicateness, flavor, and mellowness, etc., of the fruit," the doctor intermixes adjectives so with bad odors as to be really *faeces*-tious and funny. "Every cloaca in town surrendered its contents," i.e., in Dr.

Ramsey's imagination, not in Greenville; and he couldn't convict the citizens of the place of such misdemeanor, if he even had Mark Twain's Virginia City jury to sit on the case. To come to plain truth, during my long residence in Greenville I never in all my life saw or heard of a citizen emptying his privy-vaults as manure upon anything; and any man saying to the contrary is talking about something of which he is profoundly ignorant. How kind of a philanthropist to cast the foulest of aspersions upon the people of a little remote village, and, regardless of all truth and fairness, give forth such an opinion of "men, women, and children" as to lead the editor of this journal to say, "Greenville was punished for the most reckless disregard of the first principles of sanitary science, if not of common decency."

Now, Mr. Editor, if Dr. Ramsey had with a ten-pound Parrott gun mounted that "eastern slope," and loaded it with human excrement, firing it off every ten minutes during the day, he couldn't more literally have befouled the town than he has in the extract you quote in your editorial; and if he should walk the streets of Greenville and strike every "man, woman, and child" in the face with a handful of the contents of that "immense pit," (?) he couldn't insult them worse than he has by flinging his *faecal* report to the general public. In considering the unreliability of the facts he put forth in his report, I conclude by saying that it invalidates any of his deductions as to the cause of cholera in Greenville; and I hope to prevent any such report being placed upon the statistical tables of cholera; and, if space permitted, I could show that the cholera extended right in the opposite direction from the excrementitious-washed part of the town.

Very respectfully,
JAMES D. MCGAUGHEY, M.D.

WALLINGFORD, CONN., July 21, 1873.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR:—One swallow doesn't make a summer; but the following result or coincidence astonished me, and seems worthy of record. I was called to see Mrs. S., aged 35, in labor with her ninth child. Very early in her seventh and eighth labors the womb had entirely given out, so that the child had to be delivered with forceps, although all the mother's parts were roomy and well relaxed. After the births severe flooding occurred.

At the time of my arrival, 12 midnight, there were some slight pains. At 3 A.M. the bag of waters broke; the os being soft, relaxed, and about an inch and a half in diameter. The pains shortly died entirely away, and at 4.55 A.M. the os was exactly as it had been at 3 A.M. I now exhibited four grains of quinine, and at 5.6, six grains more, all in solution. Shortly after the last dose she began to have cutting, grinding pains of some severity; but, having made up my mind that, as on the previous occasions, delivery with the forceps would be required, I was sitting in the next room, when at 6 A.M.

I was startled by the cry, "Come, quick! it's coming!" And, sure enough, on entering the room I found the head protruding from the vulva. It seems that there had been two sudden, long, hard, expulsive pains, which had completed the labor. The womb continued to contract; a female child of good size was soon born. The womb immediately became a "cannon-ball;" no blood was lost, and all went "merry as a marriage bell."

Yours,

OBSTETRICIAN.

PHILADELPHIA, July 26, 1873.

PROCEEDINGS OF SOCIETIES.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

At a conversational meeting held April 23, 1873, at 8 o'clock P.M.,

Dr. W. B. ATKINSON, PRESIDENT, in the chair,

Dr. H. LEAMAN presented a pathological specimen of an *appendix cæci*, showing gangrene to the extent of an inch in its lower portion, in which there was a minute perforation. The appendix was of the usual length, presenting a patulous orifice on the cæcal surface, and lodged in its cul-de-sac a date-seed, which had separated into two parts. The gangrene and perforation were close to the seed, and between the seed and the inlet of the appendix.

The patient, a boy 14 years of age, was taken sick April 9, 1873, with sickness of the stomach, and vomited his dinner. When the doctor saw him, the next day, there was a resonant tumor in the right iliac fossa, with general abdominal tenderness. The constitutional symptoms were slight, and the patient anæmic. He died Sunday, April 13, 1873.

The post-mortem, sixteen hours after, showed, in addition to the above, a film of pus over the general peritoneal surface, with an accumulation of pus around the cæcum.

Dr. A. D. HALL said that a few years ago he had gone to the trouble of looking up these cases, and had accumulated fifty-eight or fifty-nine similar to the one just mentioned.

Dr. R. BURNS remarked that he was reminded of a somewhat similar case in his practice in 1851. The subject was a girl about 7 years of age. In the fall of that year she had dysentery, with much pain and great emaciation, which continued several weeks and resisted every means used for her relief. Acute enteritis was evidently manifest, which resulted in death.

On the 30th of November, 1851, a post-mortem examination was made, when a penetrating ulcer was discovered at the ileo-cæcal valve, in which was found a large grape-seed, which doubtless was the chief cause of the child's suffering and death.

Dr. BURNS said he believed many children perished by such causes, when their cases seemed to be mysterious and unaccountable.

Dr. J. S. ESHLEMAN referred to a case of inflammation of the cæcum, occurring in the person of his brother-in-law. Two years before his death he swallowed a piece of oyster-shell. During those two years he had occasional suffering and trouble. He died from an inflammation which lasted forty-eight hours. The piece of oyster-shell was removed from the ileo-cæcal valve, and the bowel was found thickened to the extent of three-fourths of an inch, but perforation had finally

taken place. The doctor spoke of the propriety of removing the foreign substance in such cases.

Dr. H. Y. EVANS stated that he had seen cases of ulceration and dilatation of the appendix, yet in none of them had this abnormal condition been the cause of death. He had within a few days been present at a post-mortem in which the appendix was quite thin from fæcal distention, and he had no doubt that inflammation of the bowels occasionally has its origin in this vermicular process.

Dr. F. J. BUCK remarked that he had been using, for several years, at the suggestion of Dr. A. Nebinger, the sulphite of soda in the treatment of erysipelas. He was thoroughly impressed with the value of this agent, used internally and externally, both in the form of the sulphite and bisulphite.

Dr. L. TURNBULL had employed the sulphite and bisulphite of soda in "purpura." He was aware that it was a disease of debility, and in the treatment he had resorted to the use of good diet, tonics, such as the mineral acids, quinine, and iron, with acidulous drinks. Yet all these means failed to relieve his patients of the swelling and sanguineous patches of various sizes from the ankle to the knee. He then used these preparations of soda, administering teaspoonful doses, diluted in water, every three hours, and found the most happy results to follow. The pain and swelling disappeared, and the skin assumed its natural color, etc. He had used this remedy with perfect success in several cases.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, JUNE 26, 1873.

THE PRESIDENT, DR. J. H. HUTCHINSON, in the chair.

Dr. O. H. ALLIS presented a specimen of *popliteal aneurism*, which is the subject of an original communication in No. 92 of the *Medical Times*.

Dr. JAMES TYSON exhibited a specimen of *occlusion of the common bile-duct*, with apparent disappearance of the gall-bladder proper, its contents mingled with blood being contained in a cavity in the substance of the liver. (See a clinical lecture in No. 88, July 5, of the *Medical Times*, where the post-mortem appearances are also described.)

Dr. J. EWING MEARS presented portions taken from a specimen of *tumor of the right ovary* removed by Dr. Washington L. Atlee from a patient æt. 32. The growth from which the portions exhibited were taken was chiefly interesting owing to the fact that in it were presented two morbid structures, which were connected, though not related,—one of a benign, the other of a malignant character. The former consisted of a cyst containing a large quantity of fluid, whilst the latter was a large solid mass, projecting into, and, as it were, forming part of the wall of, the cyst; the greater portion of the mass, however, was exterior to the cyst.

The wall of the cyst was very dense, requiring some force to penetrate it with the trocar. The lining membrane was smooth, and did not differ in any respect from that of simple unilocular cysts. The fluid by microscopic examination presented the usual characters of the fluid of simple ovarian cysts.

On section and examination of the solid mass, it was found to be malignant in character, of the alveolar or colloid variety of cancer.

In remarking upon this specimen, Dr. MEARS alluded to the difficulties which presented themselves in determining, prior to operation, the nature of the morbid growth; more especially in reference to its benign or malignant character. The solid portion of the tumor

was firmly lodged in the pelvic cavity, and was in very intimate relation with the uterus, rendering it quite difficult to decide that it was not in some way connected with that organ.

Palpation and percussion determined very positively that the abdominal cavity was occupied by a cyst containing fluid. Tapping was performed, and a specimen of the fluid was submitted to careful examination. It did not vary from that usually found in simple ovarian cysts, either in its microscopical or chemical characters. The microscope did not show in the fluid any cell-structures which would have determined its origin from a cancerous growth. On a previous occasion Dr. MEARS had been able to diagnose the malignant nature of the tumor of the ovary by microscopic examination of the fluid contents removed by tapping, as was proved by post-mortem examination.

In this case, as clearly seen after the operation, the distinct separation between the two portions of the tumor prevented the discovery of its nature by examination of the fluid.

A diagnosis of multilocular tumor of the ovary (non-malignant) was, therefore, very naturally made. Another interesting question was suggested in discussing this specimen, relating to the priority of the morbid growths: whether, in this case, the ovary was primarily occupied by the cystic growth and subsequently became the seat of cancer, or the reverse. The history of the case is that of rapid development, covering a period of about nine months. The appearance of the tumor seems to indicate that the cancerous portion was developed subsequent to the cystic growth.

REVIEWS AND BOOK NOTICES.

SKIN DISEASES: THEIR DESCRIPTION, PATHOLOGY, DIAGNOSIS, AND TREATMENT. By TILBURY FOX, M.D. Lond. Second American, from the Third London Edition, re-written and enlarged, with a Cutaneous Pharmacopœia, a Glossarial Index, and sixty-seven additional Illustrations. New York, William Wood & Co., 1873.

The third edition of Dr. Fox's work upon diseases of the skin appeared in London a few months ago, and already, through the zeal of Dr. Henry, of New York, we are so fortunate as to possess another American edition, which reflects credit alike upon editor and publisher. The book is very well known, and since the publication of the first American edition has been extensively employed in our universities as a student's manual; but with the present edition its popularity must greatly increase, many marked improvements and changes being everywhere visible. The volume has been enlarged, and in parts so altered that the original is scarcely recognizable amid the quantity of new material to be found upon every page. We notice many of the chapters entirely re-written as well as re-arranged. Large numbers of illustrations have been introduced, borrowed almost exclusively from the publications of the German investigators, to whom modern dermatology is so much indebted for awakening an interest in pathological research. It must be gratifying to students of all nationalities to observe the friendly and generous spirit with which Dr. Fox has made use of and brought forward the studies which have of late appeared in both this and the Old World. This liberal kindly feeling for the true student, of whatsoever country he may be, is manifest throughout the entire work, and shows plainly the broad views which our author has adopted.

The present edition is nearly double the size of the former, and contains much new and original matter.

Pathology is accorded a prominent position in the consideration of each disease, the author not only giving his own views, but also those of other writers. The description of the diseases is given in an easy colloquial style, without attempt at routine or formality; more condensation, perhaps, would have rendered the volume more acceptable as a scientific work. We observe also that many of the chapters have evidently been written in great haste; this is particularly noticeable towards the end, where certain diseases scarcely receive sufficient space. The book, however, taken as a whole, is an eminently good one, and well deserves the high position which it holds. We cheerfully recommend it as being the best work upon diseases of the skin which Great Britain has yet produced, and we wish it the success which it merits.

ACCOMMODATION AND REFRACTION. A Review of Dr. Fenner's Pamphlet. By DUDLEY P. REYNOLDS, M.D. Reprinted from the *American Practitioner* for July, 1873.

This pamphlet is another example of misspent time and labor. Its intention is to point out some glaring errors in a treatise on "Accommodation and Refraction," by Dr. Fenner; and in following out this idea the critic has held up to ridicule some slight misstatements which do not deserve the extended notice he has given them.

It is to be hoped that in the future a similar amount of energy will be displayed in a more worthy cause.

GLEANINGS FROM OUR EXCHANGES.

TRAUMATIC RUPTURE OF THE TYMPANIC MEMBRANE (*British Medical Journal*, June 7, 1873).—Mr. W. B. Dalby reported ten cases of this accident. In six of them the wound healed, and, when no inflammation in the tympanic cavity followed, a few days sufficed for the perforation to close. In the other four cases the wound did not heal at all. When suppuration had been once established in the tympanic cavity the treatment pursued was the same as in cases where the perforation had been the result of disease, and consisted chiefly in the use of astringents. No treatment was adopted when the injury was not followed by inflammation of the tympanum. It was found that the injury to the nervous structure of the ear behind the tympanum caused the loss of hearing, rather than the injury to the membrane, and that the greatest loss of hearing followed those accidents in which the greatest force was used in producing the rupture.

DEATH UNDER METHYLENE ETHER.—On Saturday last a patient on whom Mr. Lawson Tait was just about to perform ovariectomy, at the Birmingham Hospital for Women, died suddenly after the administration of five drachms of methylene ether. The anæsthetic was given through a single fold of a towel by the resident medical officer, and nothing noteworthy was observed during its administration. The pulse suddenly stopped, the pupils became dilated, and the respiration subsequently ceased. All efforts at restoration were fruitless. Post-mortem examination did not reveal the cause of death, the heart and all the other organs, except the ovary, being quite healthy. During life a halenic murmur at the base had been detected.—*London Lancet*.

NATURE OF MUMPS.—In a note on the above, read to the Academy of Sciences by Claude Bernard, the author, Dr. Bouchut, states that parotitis is simply a salivary retention due to catarrhal inflammation of the excreting canal of the parotid.—*London Lancet*.

PARALYSIS OF THE RADIAL NERVE CONSEQUENT ON EXPOSURE TO COLD.—At a recent meeting of the Société de Biologie, at Paris, M. Vulpian brought forward an interesting case of paralysis of the extensors of the forearm. In the month of January last, a man, aged 43 years, slept in a very cold and damp room, and awoke with a sense of chill, numbness, and tingling in the right hand and forearm, attended with complete loss of power over the extensors of the wrist and fingers. He was perfectly sober, and had lain on his right side, with the right arm outside the bed, naked and pronated, and with his head resting on the external part of the arm. The muscles reacted energetically to direct faradization, which was employed for six weeks without any benefit. It was then perceived that direct electrization of the radial nerve had no effect on the extensors of the hand and fingers, and when the electric treatment was applied directly to the nerve the patient speedily recovered. M. Vulpian thinks it probable that the paralysis in this case was due to the action of cold on the points where the motor-nerve fibres enter into an intimate connection with the primitive fasciculi of the extensor muscles of the hand and fingers. If this be so, the case would be somewhat analogous to what obtains in animals deeply curarized. In them, as we know from C. Bernard's experiments, the motor nerves preserve their excitability, and the muscles their contractility, and yet electrization of the motor nerves produces no contraction in the muscles supplied by these nerves.—*La Tribune Médicale*, 27th April, 1873.

NIGHT-SWEATS OF PHTHISIS.—In some valuable notes of practice in the Bellevue Hospital, New York, published in the *Medical Record* of that city, we find that for the relief of the above exceedingly troublesome symptom some patients are taking $\frac{1}{8}$ of a grain of sulphate of atropia in solution *ter in die*; some are taking $\frac{1}{16}$ of a grain at bedtime, and the success of this mode of treatment has already been sufficient to entitle it to further trial. Another plan of treating these night-sweats is also practised. It consists in taking the patient out of bed, if found sweating profusely in the night, sponging him with water as hot as he can comfortably bear, and, after being wiped dry and having his flannels replaced, putting him back to bed. It is stated that sometimes a single sponging will arrest the sweating for two or three days. In the French hospitals, according to a recently published thesis of M. Finot (*Rev. des Sciences Méd.*), agaric, tincture of aconite, phosphate of lime, etc., are employed for the same purpose. The reporter in the latter periodical, M. Rabuteau, speaks highly of the efficacy of phosphate of lime.

GENERAL USES OF DIRECT AND INDUCED CURRENTS (*Irish Hospital Gazette*, July 1, 1873).—Walter G. Smith, M.D., in a lecture on the Clinical Uses of Electricity, thus tabulates the therapeutic distinctions between the two forms of current:

DIRECT.	INDUCED.
To excite the nerves of special sense.	To stimulate the cutaneous nerves.
To reduce muscular spasm directly.	To antagonize muscular spasm by exciting the opposing muscles.
To produce chemical and thermal changes, e.g., coagulation of blood, electrolysis, cautery.	
To stimulate muscles in certain cases.	To stimulate muscles in the majority of cases, and generally to obtain energetic peripheral excitation.
To relieve neuralgic conditions.	
To affect the brain and spinal cord directly, especially the latter.	

AMYKOSASEPTIN: AN ANTISEPTIC.—Amykosaseptin, or amycetoseptin, is an antiseptic consisting of a solution of borax combined with decoction of cloves. The author of a paper in *Allg. Med. Cent. Zeit.*, No. 46, 1873,

thus describes its action: 1. Boric acid prevents bacteria from penetrating into the tissues, and thus prevents rot. 2. It destroys bacteria which may already exist in the tissues, and thus arrests rot. 3. It speedily kills true infusoria. 4. It is often a deadly poison for articulated animals and their larvæ. 5. It does not prevent the development of mildew. 6. The decoction of cloves only possesses in a limited degree the property of preventing the development of mildew, but it certainly delays the process and renders it difficult.—*London Lancet*.

ANTI-NEURALGIC SNUFF.—The *Rivista Clinica di Bologna* mentions an anti-neuralgic snuff prescribed with success in cases of facial neuralgia, by Dr. Scriffignano. The base of the snuff is quinine, and its composition as follows: Citrate of quinine, ten grains, very strong; exciting snuff (tobacco), fifteen grains. The medicament is said to act almost directly on the diseased nerve through the ethmoidal thread of the nasal ramus of Willis's ophthalmic, a branch of the fifth pair.—*London Lancet*.

CYSTOTOMY FOR SPASM OF THE NECK OF THE BLADDER.—Dr. Francesco Parona (Novara) reports in full in the *Rivista Clinica di Bologna* (May 10, 1873) two cases of spasm of the neck of the bladder cured by cystotomy, with the following conclusions: 1. The most certain means to cure this affection is incision of the neck of the bladder. 2. The operation of cystotomy is preferable to intra-urethral section.—*The Clinic*.

MISCELLANY.

A NEW poison has lately been discovered, called *inewā*, which is said to be more subtle than digitaline. It is obtained, by pressure, from the seeds of *Strophanthus hispidus*, an apocynaceous plant, found in Gaboon; and from experiments made with samples of it, taken from arrows, upon which the natives place it, it appears to act more powerfully than even digitaline, and quickly paralyzes the heart. Three milligrammes kill a frog, a sparrow, or a dog; though the resistance of certain animals varies. A snail, for instance, requires five milligrammes; a mouse has withstood three milligrammes of the extract (obtained by macerating the seeds in alcohol), while this latter dose kills a dog nearly a thousand times heavier than the mouse. The heart comes to a complete stand-still after a few irregular efforts.—*New York Medical Review*.

PROGRESS IN MICHIGAN.—Miss Dr. Frances A. Rutherford is Fourth Vice-President of the Michigan State Medical Society. She attended the recent session of the State Medical Society at Saginaw City. It is believed that this is the first instance of a woman's holding such a position in such a society in this country. Miss Rutherford is a graduate of a Philadelphia Medical College.—*Medical and Surgical Reporter*.

FROM Lord Bacon downwards, statesmen have frequently sought in scientific research a solace from the cares of office. M. Thiers is the last case in point. Deep in the Darwinian hypothesis, he is engaged on a work respecting the origin of the human species.—*London Lancet*.

MR. F. A. BURR, editor of the Pottsville *Daily Standard*, writes as follows concerning the notorious Wharton trials:

"REVIVING A DEAD ISSUE.

"The circumstances preceding and attending the trials of Mrs. Wharton, in Annapolis, Maryland, for the alleged poisoning of General Ketchum and an attempt on the life of Eugene Van Ness, of Baltimore, are of such a nature as to lead one to suppose that, after the result of the trials, the whole matter would be allowed to rest in peaceful and proper oblivion. As the trials, the first at least, have attained the dignity of *causes célèbres*, we might naturally expect to find them made the fruitful source of parallels and precedents, by lawyers engaged in kindred cases; but that the medical fraternity, especially the experts who appeared for the prosecution, should continue to agitate the equivocal part there played by learned doctors, is singular, and not at all to their credit or reputation.

"In the beginning of the persecution levelled by the Baltimore college against Mrs. Wharton, there was very evidently more a feeling of professional pique, inciting the three leading medical witnesses for the State, than a desire for equal and exact justice. The most remarkable hesitation and shifting marked the determinations of the wise men who were experimenting on the body of General Ketchum; we say experimenting, for there did not appear a single evidence that intelligence had any part in the post-mortem examination. The symptoms which marked his illness and the circumstances attending his death were neglected, and a regular hunt after one hypothetical poison and another took place, the settlement being finally made on tartar emetic. Professor Aiken, the ancient chemist who conducted the first analysis, having arrived at a certain conclusion, whether rightfully or erroneously matters not, it seems as though his colleagues in the faculty of the medical college felt bound to endorse him, and by pen and voice, in court and out of court, by means of pamphlets, through the public press and by private channels, they strove to at once prejudice the public and shape even the verdict the jury was to render. At the time of the trial of Mrs. Wharton, being then in the service of the New York *Herald*, we made several direct and damaging charges against Drs. Chew and Williams, associated with Professor Aiken for the prosecution, which neither they nor their friends have had the temerity to deny, concerning this illegal and unprofessional conduct of everything connected with the autopsy, charges that, being acknowledged as true, would invalidate in law the most correct deductions of science and exclude them from evidence. In the immediate vicinity of Baltimore it is well understood that the trials, which have reduced Mrs. Wharton from comparative affluence almost to penury, were incited by the physicians, kept alive through their endeavors, and only failed to stamp her as a modern Borgia through the falsity of the assumptions whereon their assertions were founded.

"The jury in the second trial disagreed; and the

State, seeing the impossibility to convict on the character of the evidence at its command, entered a *nolle prosequi*, and the proceedings, as far as the law is concerned, ended. But the faculty of the college are not yet satisfied; the erudition of these sapient professors is on trial at the greater bar of public opinion; and, as they could not hang the woman to save themselves, they keep lugging the case forward, through the medical journals, with elaborate arguments and specious pleas, challenging the verdict of the jury and imputing all sorts of motives to the witnesses, expert especially, for the defence. Neither in law nor in reason is this just. What private quarrels the opposing doctors have are more properly ventilated in private, and should be discussed in the lecture-room rather than be made immortal by being printed. What right attaches to Dr. Chew or P. C. Williams, M.D., or any other man, to declare Mrs. Wharton guilty? An expression of a belief in her guilt is within the province and privilege of every one; but we think that defeated spite is exceeding the bounds of moderation and justice when it reviews, *ex parte*, the antecedents of the trials and determines upon verdicts which intelligent juries, after hearing both sides, refused to render. Let the matter rest. The representatives of the Baltimore College faculty came off with anything but flying colors, and they should be content that the overthrow of their Castle of Knowledge has not been so complete as to leave no stone upon another."

THE Indian Medical Service has sustained a severe loss by the death of an indefatigable and conscientious surgeon. Dr. Colles, who was a Fellow of the Royal College of Surgeons of Ireland, and Doctor of Medicine of St. Andrews University, died on February 7, at Dinapore. He had been acting in the room of Dr. S. B. Partridge, as professor of descriptive anatomy in the Calcutta Medical College, and, with characteristic enthusiasm, had exerted himself to a degree beyond his strength. In his exhausted condition he contracted the seeds of enteric fever, which, rapidly developing in very malignant form, carried him off before it had reached its crisis. His death has caused deep and wide-spread sorrow.

DR. M. H. HENRY has been appointed by the Commissioners of Emigration, Surgeon-in-Chief of the State Emigrants' Hospital, Ward's Island, New York. Dr. Henry succeeds Dr. Carnochan, who has held this position for many years.

PROFESSOR D. WARREN BRICKELL, formerly of the University of Louisiana, has been appointed one of the Professors of Obstetrics and Diseases of Women and Children, and Clinical Midwifery, in the Bellevue Hospital Medical College.

TO REMOVE BAD TASTES.—The bitter taste of quinine, colocynth, aloes, quassia, and other bitter medicines, may almost instantly be removed by chewing a small piece of liquorice-root, says *La Tribune Médicale*.

HEREAFTER the returns of deaths will be published monthly, instead of weekly.